

# **Chapter 3**

## **Provider Records and Registration**



**This Page  
Intentionally  
Left Blank**



## **OVERVIEW**

Any person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation.

Providers are required to:

- ☒ Complete an application,
- ☒ Sign a provider agreement,
- ☒ Sign all applicable forms, and
- ☒ Submit documentation of their applicable licenses, certificates and/or CMS certification

Information and registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)

In-state: 1-800-794-6862 (Option 5)

Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials also are available on the AHCCCS Web site at [www.azahcccs.gov](http://www.azahcccs.gov). Click on Links for Plans and Providers on the AHCCCS home page. On the page titled Quick Links for Plans and Providers, scroll down to the Provider Registration section. All documents are in PDF format. They must be printed and completed offline and returned to the Provider Registration Unit.

AHCCCS Provider Registration Unit  
MD 8100  
P.O. Box 25520  
Phoenix, AZ 85002

When a provider's application is approved, an AHCCCS provider ID number is assigned, and the provider is notified by letter.

## DOCUMENTS REQUIRED FOR REGISTRATION

The following documents must be completed, signed by the appropriate parties, and on file with the Provider Registration Unit before an AHCCCS provider ID number can be issued:

- ☒ Provider Registration Application Form
  - ✓ This form must be completed in its entirety and signed by the provider, administrator, CEO, or owner.
- ☒ Provider Agreement
  - ✓ The Provider Agreement is a contractual arrangement between the AHCCCS Administration and the provider.
  - ✓ The agreement's form and content are consistent with Medicaid regulations, and no changes may be made to the language of the agreement.
  - ✓ By signing the agreement, the provider indicates the following:
    - ☒ The provider has read the document in its entirety,
    - ☒ The provider understands all the terms of the agreement, and
    - ☒ The provider agrees to all of the stipulations in the agreement.
  - ✓ Any provider who violates the terms of the agreement is subject to penalties and sanctions.
  - ✓ The Provider Agreement remains in effect until terminated by either the AHCCCS Administration or the provider.
  - ✓ The agreement for long term care facilities must be renewed annually, concurrent with the expiration date (survey date) for Medicare/Medicaid recertification.
  - ✓ This agreement is required of all providers, including one-time-only providers.
- ☒ Proof of licensure and certification
  - ✓ All providers must meet licensure/certification requirements applicable to their provider types as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.
  - ✓ Documentation of all licenses and certifications must be provided.
  - ✓ IHS providers do not require an Arizona license, as long as the provider has a valid license in another state.
- ☒ Form W-9: Request for Taxpayer Identification Number and Certification
- ☒ CMS certification for tribal providers



## **PROVIDER TYPES AND CATEGORIES OF SERVICE**

All AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The AHCCCS Provider Registration Unit will help providers identify the most appropriate provider type, based on the provider's license/certification and other documentation.

Within each provider type, mandatory and optional categories of service (COS) are identified.

- ☒ Mandatory COS are defined by mandatory license or certification requirements.
  - ✓ The provider must submit documentation of licensure and/or certification for each mandatory COS.
- ☒ Optional COS are those that the provider may be qualified to provide and chooses to provide.
  - ✓ Optional COS which do not require additional licensure and/or certification are automatically posted to the provider's file.
  - ✓ Optional COS which do require license/certification are posted once proof of current, valid licensure and/or certification is received.

Mandatory and optional COS, licensure/certification requirements, and the applicable procedure codes for each provider type are listed in the Provider Profile. Providers may be limited to certain procedures within a COS. If limitations are applicable, the allowable procedures are identified in the Provider Profile.

## **REGISTRATION OF IHS PROVIDERS**

An IHS facility must be a federally qualified and certified in order to be registered as an AHCCCS provider. Services provided by the facility must be in accordance with the inter-governmental agreements that are in place between IHS, AHCCCS and/or CMS.

Individual IHS providers are registered under one of 18 provider types:

- ☒ MD - Physician
- ☒ DO - Physician Osteopath
- ☒ Podiatrist
- ☒ Dentist
- ☒ Psychologist
- ☒ Optometrist
- ☒ Physician Assistant

## **REGISTRATION OF IHS PROVIDERS (CONT.)**

Individual IHS providers are registered under one of 18 provider types (Cont.):

- ☒ Nurse Practitioner
- ☒ Certified Nurse-Midwife
- ☒ Speech Therapist
- ☒ Occupational Therapist
- ☒ Physical Therapist
- ☒ Certified Registered Nurse Anesthetist
- ☒ Respiratory therapist
- ☒ Licensed Professional Counselors
- ☒ Licensed Marriage and Family Therapists
- ☒ Licensed Clinical Social Workers
- ☒ Licensed Substances Abuse Counselors

Each IHS Area Office or IHS facility must maintain a roster of its AHCCCS-registered individual providers. As staff changes occur, including both staff additions and deletions, each IHS Area Office or IHS facility must notify AHCCCS of those changes. Each IHS Area Office or IHS facility is responsible for informing AHCCCS when one of its AHCCCS-registered providers terminates IHS employment.

Each physician and mid-level practitioner must complete a Provider Application packet and AHCCCS Provider Agreement. The “Pay To” address on the Provider Application must list the IHS facility with which the provider is employed, the facility address, and facility tax identification number.

A copy of the provider’s current license must be attached with the application. An Arizona license is not required if the provider has a current, valid license from another state.



## **REGISTRATION OF TRIBAL PROVIDERS**

Because tribal providers are located on Indian reservations where the Arizona Department of Health Services (ADHS) does not have jurisdiction, these providers do not have ADHS facility licenses. In place of licensure, CMS certification is required.

The tribal provider must complete the CMS certification form (available from Provider Registration) and submit the form to AHCCCS with the application. The authorized representative for the tribe must sign the certification and recertification forms indicating that the tribe certifies that the provider meets the same standards as all other AHCCCS providers and that the tribe assumes full liability for the certified provider. If someone other than the tribal chairman signs the form, CMS will need documentation to show that the person signing the form has the authority to sign for the tribe.

The Provider Registration staff will review the provider application and CMS certification submittal and forward it to CMS for its approval. CMS will notify Provider Registration that the tribe is certified to provide services. Provider Registration then will notify the tribe of CMS's certification or recertification.

On the initial certification, Provider Registration will notify the tribal provider of the AHCCCS provider ID number, when the registration process is complete.

Tribal providers seeking recertification should request the forms from Provider Registration at least 90 days before the current certification expires.

## **GROUP BILLING**

An AHCCCS-registered IHS facility or a tribal facility or organization wishing to act as the financial representative for a provider or group of providers who have authorized this arrangement may register as a group billing provider. Group billers may not provide services or bill as the service provider.

The service provider must sign a Group Billing Authorization form that allows the group biller to submit the provider's claims and receive the provider's AHCCCS payments. Forms may be obtained from the AHCCCS Provider Registration Unit.

The tribal administrator or the IHS facility administrator must sign the group biller application form.

The service provider's AHCCCS provider ID number must appear on each claim, even though a group billing number may be used for payment.

The provider will remain affiliated with the authorized group until the provider furnishes written notification, signed by the authorized signer or the provider, to the Provider Registration Unit indicating a termination from the group billing arrangement.

All payments for the service provider will be sent to the pay-to address of the group billing provider with whom the service provider is affiliated if the group billing provider ID number is entered on the claim.

IHS group billers must use the facility's "pay to" address and tax ID number.

## CORRESPONDENCE, PAY-TO, AND SERVICE ADDRESSES

AHCCCS maintains a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider except group billers. For group billers, AHCCCS maintains a correspondence address and a pay-to address.

- ☒ The *correspondence address* is the address where billing instructions, letters, and all other correspondence, except checks, are mailed.
  - ✓ Each provider has only one correspondence address, even if a provider has multiple service addresses.
- ☒ The *pay-to address* is the address on the paper reimbursement check from AHCCCS.
  - ✓ The Remittance Advice, along with the paper reimbursement check, are mailed to the provider's pay-to address as determined by the provider's tax identification number (See below).

**NOTE:** ACH payments (electronic reimbursement) are sent directly to your bank. Paper copies of the Remittance Advice are mailed to your pay-to address. If your pay-to address is a lockbox at the bank, you should contact the Provider Registration Unit to change the pay-to address to the location where your payment posting occurs. This will prevent delays in receiving the remits from the lockbox. Should duplicate remits be required, the AHCCCS Finance Unit charges \$2.00 per page to reproduce.

- ☒ The *service address* is the business location where the provider sees patients or otherwise provides services.
  - ✓ A locator code (01, 02, 03, etc.) is assigned to each service address.
  - ✓ As new service addresses are reported to AHCCCS, additional locator codes are assigned.
  - ✓ When a service address is no longer valid, the provider must notify AHCCCS, and that service address locator code will be end-dated.





## **TAX IDENTIFICATION NUMBER**

A provider's tax identification number (TIN) determines the address to which payment is sent. AHCCCS requires providers to enter their TIN on all fee-for-service claims submitted to the AHCCCS Administration.

Previously, a provider's two-digit service address locator code (01, 02, 03, etc.) was linked to one or more pay-to addresses. The locator code determined the address to which payment was sent.

Providers should continue to append the service address locator code to their AHCCCS provider ID number to indicate the location where a service was performed. However, using the locator code will no longer direct payment to a specific address.

Providers must enter the appropriate TIN on the claim form to direct payment to the correct address. If no TIN is on file, the AHCCCS system will deny the claim because it will be unable to direct payment to a specific address.

If a provider's record shows more than one address linked to a TIN, the system will direct payment and the Remittance Advice to the first address with that TIN. Providers who want reimbursement checks directed to more than one address must establish a separate TIN for each pay-to address.

## **CHANGES TO INFORMATION ON FILE**

It is the provider's responsibility to notify Provider Registration in writing of any changes to the information on file at AHCCCS. Failure to report changes may result in misdirected payments and correspondence and could result in the termination of provider status or recoupment of payment.

All changes to information on file must be signed by the provider or the provider's authorized representative.

Changes that must be reported include, but are not limited to, changes affecting:

☒ Licensure/certification

✓ A copy of the licensure or certification document should accompany notification

- ☒ Addresses (correspondence, pay-to, and/or service)
  - ✓ Change of address forms are available from the Provider Registration Unit.
  - ✓ When a provider changes an address, a letter is sent to the provider for verification.
  - ✓ If the information on the verification letter is incorrect, the provider should indicate the necessary changes, sign the letter, and return it to the Provider Registration Unit.
  - ✓ If the information on the verification letter is correct, the provider need not respond.
- ☒ Name
  - ✓ A letter advising AHCCCS of the name change and supporting documentation (marriage license, divorce decree, or a copy of the provider's current license) is required.
- ☒ Group billing arrangements

## MEDICAL RECORDS

As a condition of participation, a provider must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program. Such records shall be provided at no cost to the AHCCCS Administration.

The recipient's medical records must be maintained in a current, detailed, organized, and comprehensive manner that permits effective review. Records must be legible and reflect all aspects of care, including ancillary services.

## TERMINATIONS

There are several reasons a provider's participation in the AHCCCS program may be terminated.

- ☒ Voluntary termination
  - ✓ A provider may voluntarily terminate participation in the program by providing 30 days written notice to:

AHCCCS Provider Registration Unit  
MD 8100  
P.O. Box 25520  
Phoenix, AZ 85002
- ☒ Loss of contact
  - ✓ AHCCCS may terminate a provider's participation due to loss of contact with the provider.
  - ✓ Contact is considered to be lost if mail is returned as undeliverable by the Postal Service.



- ✓ Providers must inform the Provider Registration Unit of any address changes to avoid misdirected or lost mail and possible termination of provider status.
- ☑ Inactivity
  - ✓ Provider participation may be terminated if the provider does not submit a claim to the AHCCCS Administration or one of the AHCCCS-contracted health plans or program contractors within a 24-month period.
- ☑ Termination for cause
  - ✓ The AHCCCS Administration has the right to terminate participation in the program by providing 24 hours written notice when it is determined that the health or welfare of a recipient is endangered; that the provider fails to comply with federal and state laws and regulations; or there is a cancellation, termination, or material modification in the provider's qualifications to provide services.
  - ✓ A provider determined to have committed fraud or abuse related to AHCCCS or ALTCS or the Medicaid program in other states may be terminated or denied participation.
    - ☑ This provision is also extended to providers terminated from Medicare participation.
  - ✓ Providers who AHCCCS determines to be rendering substandard care to AHCCCS or ALTCS recipients may be terminated, suspended, or placed on restrictions or review.
    - ☑ Restrictions may be placed on the scope of services, service areas, or health plan participation, or other limitations imposed related to quality of care.
  - ✓ If the provider's mandatory license or certification is revoked, is suspended, or lapses, the provider's participation may be terminated or suspended.

## **SANCTIONS**

Providers may be sanctioned by AHCCCS for violations of the terms of the Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the provider. The decision to sanction will be based on the seriousness of the offense, extent of the violation, and prior violation history.

AHCCCS may impose any one or any combination of the following sanctions against a provider who has been determined to have abused the AHCCCS or ALTCS programs:

- ☒ Recoupment of overpayment
- ☒ Review of claims (prepayment or postpayment)
- ☒ Filing a complaint with licensing/certifying boards or agencies or with local, state or federal agencies
- ☒ Peer review
- ☒ Restrictions (e.g., restricted to certain procedure codes)
- ☒ Suspension or termination of provider participation

AHCCCS may impose any one or a combination of the following sanctions against a registered provider who AHCCCS has determined to be guilty of fraud or convicted of a crime related to the provider's participation in Medicare, Medicaid, AHCCCS, or ALTCS programs:

- ☒ Recoupment of overpayment
- ☒ Suspension of provider participation
- ☒ Termination of provider participation
- ☒ Civil monetary penalty
- ☒ Criminal prosecution

## **NOTICE OF ADVERSE ACTION**

The Provider Registration Unit will provide written notice of termination or suspension to providers which will include the effective date, the reason, and the provider's grievance rights.

- ☒ Actions based on fraud or abuse convictions are effective on the date of the conviction.
- ☒ Actions due to revocation, suspension, or lapse of licensure or certification are effective the date that the license or certification becomes invalid.
- ☒ Actions due to the quality or appropriateness of care provided are effective on the date specified by the AHCCCS Office of Special Programs.
- ☒ All other adverse actions are effective 15 calendar days from the date of notification.

For adverse actions requiring 15 calendar days notice, the provider may submit evidence to Provider Registration disputing the action within 15 calendar days of the date of the notice. Provider Registration will review all documentation received by the first workday following the expiration of the 15-day notice period.

If Provider Registration confirms that the provider is eligible to participate, a notice will be sent to the provider verifying that no action will be taken to terminate participation.



Providers may grieve any adverse action including termination, suspension, and restriction (See Chapter 19, Grievances).